

CERTIFICATE OF DEATH

06639

Reg. Dist. No.

6645

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Plum Point</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>County Hosp.</u>				d. STREET ADDRESS <u>Prince Frederick</u>			
3. NAME OF DECEASED (Type or print) First <u>Maggie</u> Middle <u>Bayer</u> Last <u>Bayer</u>				4. DATE OF DEATH Month <u>6</u> Day <u>9</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 2</u>	9. AGE (In years last birthday) <u>93</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Jacob Broom</u>			
14. MOTHER'S MAIDEN NAME <u>Cornelia Houston</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Marion Harold Plum Point</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Hip (Femur)</u> <u>9040</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>May 9 1958</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Plum Pt. Calvert Md.</u>		20g. (County) <u>Calvert</u>		20h. (State) <u>Md.</u>		20i. (City or town) <u>Plum Pt. Calvert Md.</u>	
21. I certify that I attended the deceased from <u>May 10</u> , 19 <u>58</u> , to <u>May 12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>May 12</u> , 19 <u>58</u> , and that death occurred at <u>12 noon</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Page C. Jeff</u>				ADDRESS (Street, city or town, state) <u>Prince Frederick Md.</u>			
PHYSICIAN'S NAME (Type) <u>Page C. Jeff</u>				DATE SIGNED <u>6/1/58</u>			
22a. (BURIAL) CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-12-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Edmund</u>		22d. LOCATION (City, town, or county) (State) <u>Sundeland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.E. Sewell, Prince Fred, Md.</u>				24a. REC'D BY REGISTRAR DATE JUN 17 '58		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

NAME

RESIDENCE

11-10-1911

11-10-1911

11-10-1911

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6646 CERTIFICATE OF DEATH

Reg. Dist. No.

06640

1. PLACE OF DEATH o. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>				d. STREET ADDRESS <u>MD.</u>			
3. NAME OF DECEASED (Type or print) First <u>Leroy</u> Middle <u>A.</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>6</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/10/02</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brick Mason</u>		11. BIRTHPLACE (State or foreign country) <u>Lower Marlboro MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Barriett</u>				14. MOTHER'S MAIDEN NAME <u>Ellis Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mrs. Pauline V. Brown</u> Address <u>Huntingtown, MD.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442x</u> DUE TO <u>Cardiovascular senile disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO <u>Acute dilatation of heart</u> (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> <u>1 yr</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 1</u> , 19 <u>58</u> , to <u>6/10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/10</u> , 19 <u>58</u> , and that death occurred at <u>7:34 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. W. Ward</u> M.D. <u>Cummins</u>				DATE SIGNED <u>MD 6/12/58</u>			
PHYSICIAN'S NAME (Type) <u>H. W. Ward</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/13/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Plum Point Church</u>		22d. LOCATION (City, town, or county) (State) <u>Plum Point, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leroy E. Berry</u> Address <u>Huntingtown, MD.</u>				24a. REC'D BY REGISTRAR <u>W. Beach</u>		24b. REGISTRAR'S SIGNATURE	
				DATE <u>JUN 16 '58</u>			

County of Albany

City of Albany

Dec 10 1900

Page 1

Name of deceased John J. Smith
Age 45 Sex Male
Date of death Dec 10 1900
Place of death Home

Cause of death Heart failure
Died at Home
Buried at St. John's Church

Signature of physician John J. Smith
Signature of registrar John J. Smith
Signature of undertaker John J. Smith

Signature of coroner John J. Smith
Signature of justice of the peace John J. Smith
Signature of health officer John J. Smith

Signature of clerk John J. Smith
Signature of auditor John J. Smith
Signature of treasurer John J. Smith

Signature of collector John J. Smith
Signature of assessor John J. Smith
Signature of comptroller John J. Smith

Signature of sheriff John J. Smith
Signature of constable John J. Smith
Signature of justice of the peace John J. Smith

Signature of health officer John J. Smith
Signature of registrar John J. Smith
Signature of undertaker John J. Smith

Signature of coroner John J. Smith
Signature of justice of the peace John J. Smith
Signature of health officer John J. Smith

6647 CERTIFICATE OF DEATH

Reg. Dist. No.

06641

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lenzer Middle Benjamin Last Cox				4. DATE OF DEATH Month June Day 18 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 12, 1897		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Walter Cox				14. MOTHER'S MAIDEN NAME Susan P. Hardesty			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or date of service) World War I		16. SOCIAL SECURITY NO. 217-36-6988		17. INFORMANT Mrs Lenzer Cox Address Huntingtown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH about 46 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-16, 19 58 to 6-18, 19 58 , that I last saw the deceased alive on June 18, 19 58 , and that death occurred at 8:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Prince Frederick DATE SIGNED 6/20/58 ACTUAL SIGNATURE Page C. Jett M.D. Page C. Jett PHYSICIAN'S NAME (Type) PAGE C. JETT							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-21-58		22c. NAME OF CEMETERY OR CREMATORY Mt. Harmony		22d. LOCATION (City, town, or county) (State) Near Owings, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm H. Hutchins ADDRESS Owings				24a. REC'D BY REGISTRAR DATE JUN 24 '58		24b. REGISTRAR'S SIGNATURE Al. Search	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06642

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write nearest town) <u>Huntingtown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>James Edward Satter</u>		4. DATE OF DEATH Month <u>6</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 17, 69</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fisher</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Wm. Belle Robinson, Huntingtown</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Vascular Renal Disease</u> <u>442X</u> DUE TO <u>Old Colostomy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u> </u> DUE TO (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had been in bed a year</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month, Day, Year <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> 6/5/58 DATE SIGNED			
ACTUAL SIGNATURE <u>H. W. Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. W. WARD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <u> </u>		DEPUTY MEDICAL EXAMINER <u> </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 7, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Burman Island Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Calvert Co - Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. D. Harkness & Son - Huntingtown, Md.</u>		24a. REC'D BY REGISTRAR <u> </u>	24b. REGISTRAR'S SIGNATURE <u> </u>
DATE <u>JUN 9 '58</u>		DATE <u> </u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
Place of Death		Time of Death	
Cause of Death		Manner of Death	
Disease or Injury		Occupation	
Age		Sex	
Race		Religion	
Marital Status		Education	
Previous Illnesses		Previous Injuries	
Signature of Examiner		Signature of Coroner	
Date of Examination		Date of Certification	

6649

CERTIFICATE OF DEATH

Reg. Dist. No.

06643

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) g. STATE Virginia Maryland b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria 83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital		d. STREET ADDRESS 702 S. Fayette St.	
3. NAME OF DECEASED (Type or print) First Female Infant Middle Griffith Last Griffith		4. DATE OF DEATH Month June Day 22 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1958
9. AGE (In years last birthday) Newborn		10. IF UNDER 1 YEAR Months 5 Days 30	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Donald Griffith		14. MOTHER'S MAIDEN NAME Elizabeth Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Mother 702 S. Fayette St., Alex., Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unknown DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 22, 1958 , to June 22, 1958 , that I last saw the deceased alive on June 22, 1958 and that death occurred at 9:45 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) St. Leonards, Maryland DATE SIGNED June 23/58			
ACTUAL SIGNATURE Roberto de Villarreal M.D.		PHYSICIAN'S NAME (Type) Dr. Roberto de Villarreal St. Leonards, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/25/58	22c. NAME OF CEMETERY OR CREMATORY Ivy Hill	22d. LOCATION (City, town, or county) (State) Alexandria Va.
23. FUNERAL DIRECTOR'S SIGNATURE Cunningham Funeral Home, Inc. ADDRESS P. O. Box 65 Alexandria, Va.		24a. REC'D BY REGISTRAR 26 '58	24b. REGISTRAR'S SIGNATURE Robt. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1914

Form 100-1

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John A. Smith		Male		45		Jan 15, 1869		Boston, Mass.	
Cause of Death		Disease		Symptoms		Duration		Time of Day	
Heart Disease		Coronary Artery Disease		Chest Pain		2 Weeks		10:30 AM	
Place of Death		Occupation		Education		Marital Status		Religion	
Home		Teacher		High School		Married		Roman Catholic	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Death		Time of Death		Place of Death		Cause of Death		Disease	
Jan 22, 1914		10:30 AM		Home		Heart Disease		Coronary Artery Disease	
Signature of Coroner		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Physician	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6650

CERTIFICATE OF DEATH

06644

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lusby</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lusby</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u></u>				d. STREET ADDRESS <u></u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Carrie A. Grover</u>				4. DATE OF DEATH Month <u>6</u> Day <u>16</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 3, 1889</u>	9. AGE (In years last birthday) <u>68</u> yrs	IF UNDER 1 YEAR Months <u>6</u> Days <u>13</u>		IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James A. Webster</u>				14. MOTHER'S MAIDEN NAME <u>Alice M. Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>No</u> (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Calvin W. Grover, Jr.</u> Address <u>Lusby, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio vascular renal disease</u> <u>442 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead sitting at a table</u>							INTERVAL BETWEEN ONSET AND DEATH <u></u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>8 P</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>8 P</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u></u> DATE SIGNED <u>6/16/58</u>							
ACTUAL SIGNATURE <u>H. W. Ward</u> M.D.				PHYSICIAN'S NAME (Type) <u>H. W. WARD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 19, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Lusby - Calvert Co - Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Harkness & Son - Mutual, Ind</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Webb</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06645

6651

1. PLACE OF DEATH o COUNTY <u>Cabot</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> o COUNTY <u>Cabot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barstow</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barstow</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				d. STREET ADDRESS _____			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>C. EVERETT HALL</u>				4. DATE OF DEATH Month Day Year <u>June 25 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 14, 1894</u>		9. AGE (In years last birthday) <u>63 yrs</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min <u>6 11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Cabot County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles E. Hall</u>				14. MOTHER'S MAIDEN NAME <u>Estelle Bowen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-12-7035</u>		17. INFORMANT Address <u>Everett Hall - Barstow, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>6/25 1958</u> , to _____, 19____, that I last saw the deceased alive on <u>6/25 1958</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas. J. Jett</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Barstow, Cabot Co., Md. 6/27/58</u>			
PHYSICIAN'S NAME (Type) <u>Page C. Jett</u>				PRINCE FREDERICK 118			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>June 28, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ashbury Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Barstow Cabot Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.A. Harkness & Son - Mutual, Md.</u>				24. REC'D BY REGISTRAR <u>1 '58</u>		25. REGISTRAR'S SIGNATURE <u>W. J. Jett</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06646

Reg. Dist. No.

6652

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>C</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert Co</u>				d. STREET ADDRESS <u>MD</u>			
3. NAME OF DECEASED (Type or print) <u>George</u> First <u>Harper</u> Middle <u>Harper</u> Last <u>Harper</u>				4. DATE OF DEATH Month <u>6</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 13,</u>	
9. AGE (in years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Samuel Harper</u>				14. MOTHER'S MAIDEN NAME <u>Mary Hawkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u></u> Address <u></u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio vascular renal disease</u> DUE TO <u>Hypertension - Hemiplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had a headache felt in field, brought to hospital</u>							
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>B.P. 260/158</u>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Calvert MD</u>							
20c. TIME OF INJURY Month, Day, Year <u>1045</u> <u>6/3</u> <u>1958</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home farm</u>				20f. (City or town) <u>Huntingtown</u> (County) <u>Calvert</u> (State) <u>MD</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H W Ward</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u></u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u></u>		22b. DATE THEREOF <u>6-7-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>House of Pray</u>		22d. LOCATION (City, town, or county) <u>Prince Geo. Co. MD</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P E Sewell</u> ADDRESS <u>Prince Fred, Md</u>				24a. REC'D BY REGISTRAR <u></u> DATE <u>JUN 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Al Search</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



6653

CERTIFICATE OF DEATH

Reg. Dist. No. 06647

1. PLACE OF DEATH o COUNTY <i>Calvert</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <i>Maryland</i> COUNTY <i>Calvert</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lusby</i>				c. LENGTH OF STAY IN It <i>4 years</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>				d. STREET ADDRESS <i>Broomes Island</i>			
3. NAME OF DECEASED (Type or print) <i>ROBERT FRANKLIN HORMON</i>				4. DATE OF DEATH <i>June 27 1958</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr. 9, 1898</i>	9. AGE (16 years lost birthday) <i>60</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Fishing & boating</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Waterman</i>		11. BIRTHPLACE (State or foreign country) <i>Calvert Co., Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William G. Hormon</i>				14. MOTHER'S MAIDEN NAME <i>Sarah Jane Hormon</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-03-8000</i>		17. INFORMANT <i>Mrs. Carlene Hormon - Lusby, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart failure -</i>							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO (b) <i>Arteriosclerotic heart disease</i>							
DUE TO (c) <i>—</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <i>June 26, 1958</i> to <i>June 27, 1958</i> , that I last saw the deceased alive on <i>June 26, 1958</i> , and that death occurred at <i>5 P.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>R. De Villacarrere</i> M.D.				ADDRESS (Street, city or town, state) <i>5 P.M.</i>		DATE SIGNED <i>6/27/58</i>	
PHYSICIAN'S NAME (Type) <i>R. DE VILLACARRERE</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>June 29, 1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Broomes Island Cem.</i>		22d. LOCATION (City, town, or county) <i>Calvert Co., Md.</i> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. A. Harkness & Son - Mutual, Md.</i>				24a. REC'D BY REGISTRAR <i>JUL 1 58</i>		24b. REGISTRAR'S SIGNATURE <i>—</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18.

6654

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06648

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash. D.C. 16 X - 2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert County Hospital</u>				d. STREET ADDRESS <u>3407 - 37th St. Colman Manor</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ronald</u> Middle <u>Francis</u> Last <u>Jacobs</u>				4. DATE OF DEATH Month <u>June</u> Day <u>14</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/11/33</u>		9. AGE (In years last birthday) <u>24</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank W Jacobs</u>				14. MOTHER'S MAIDEN NAME <u>Mary L. Butler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>no</u>		16. SOCIAL SECURITY NO. <u>517-42-6472</u>		17. INFORMANT <u>F. W. Jacobs</u> Address <u>Colman Manor, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing injury of chest & rupture of aorta</u> <u>823X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Auto accident.</u> (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>auto hit tree</u>					
20c. TIME OF INJURY Month, Day, Year <u>7:30 a.m. 6/12 1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>road</u>		20f. (City or town) (County) (State) <u>Park Cal. Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>G. J. Weems</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>G. J. Weems</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6/18/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John's C.M. Pittston, Pa.</u>		22d. LOCATION (City, town, or county) (State) <u>Pittston, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halley's Funeral Home</u>				ADDRESS <u>1st Penna. Ave. Md.</u>		24a. REC'D BY REGISTRAR <u>J. J. ...</u>	
				24b. REGISTRAR'S SIGNATURE <u>...</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

S.S.# 579-42-6442



FOR STATE
HEALTH DEPT.

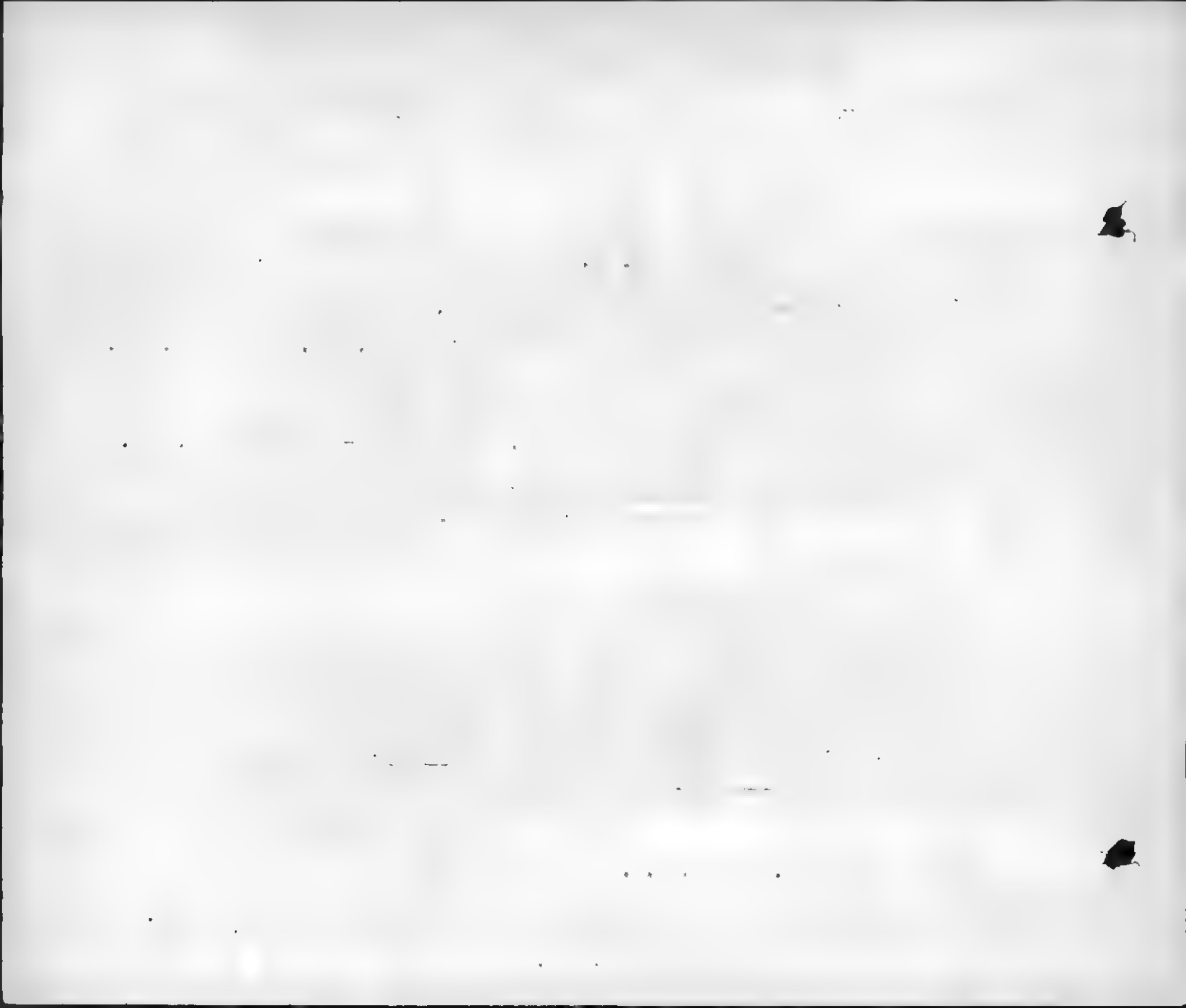
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6655

Reg. Dist. No. 06649

1. PLACE OF DEATH a COUNTY Calvert b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntingtown c LENGTH OF STAY IN life life d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 261		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a STATE Maryland b COUNTY Calvert c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntingtown d STREET ADDRESS 263	
3. NAME OF DECEASED (Type or print) CHARLES S. F. JONES		4. DATE OF DEATH Month June Day 25 Year 1958	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1890
9. AGE (In years last birthday) 69 yrs		10. IF UNDER 1 YEAR: Months 6 Days 25 Hours 19 Min. 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY same	
11. BIRTHPLACE (State or foreign country) Calvert Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Jones		14. MOTHER'S MAIDEN NAME Mary Riggs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO 217368869	
17. INFORMANT Mrs. Lula Jones-Huntingtown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Subarachnoid Hemorrhage DUE TO Ruptured Berry Aneurysm. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Paul F. Guerin, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/25/58	
22a. BURIAL CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 6/28/58	22c. NAME OF CEMETERY OR CREMATORY Cemetery Plum Point Church, Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Gregory E. Berry		24a. REC'D BY REGISTRAR DATE JUL 1 '58	
ADDRESS Huntingtown, Md.		24b. REGISTRAR'S SIGNATURE W. E. Seach	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6656 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06650

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown Md</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Albert</u> First <u>John</u> Middle <u>Lankau</u> Last <u>W</u> 4. DATE OF DEATH <u>6</u> Month <u>30</u> Day <u>1958</u> Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Oct 1 1883</u> 9. AGE (In years and months) <u>74</u> yrs. <u>7</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>W</u> 11. BIRTHPLACE (State or foreign country) <u>Md</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Albert John Lankau</u> 14. MOTHER'S MAIDEN NAME <u>Catharine Damerheim</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>W</u> 17. INFORMANT <u>W</u> Address <u>W</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO <u>Cardiac Arrest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Died at 8:40 PM</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in Bathroom</u> 19. WAS ALTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour o. m. p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>	
ACTUAL SIGNATURE <u>H W Ward</u> EXAMINER'S NAME (Type) 22a. <u>Cremation</u> 22b. DATE THEREOF <u>7/15/58</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u> 22d. LOCATION (City, town, or county) (State) <u>Pr. Geo. Co., Maryland</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>6/30/58</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H.Hines Co., 2901 14th St. Wash. D.C.</u> 24a. REC'D BY REGISTRAR <u>W</u> 24b. REGISTRAR'S SIGNATURE <u>W</u> DATE <u>JUL 2 '58</u>			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 10 days after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.



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6657

CERTIFICATE OF DEATH

06651

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sunderland</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sunderland Md</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Moore</u> Last <u>Moore</u>		4. DATE OF DEATH Month <u>6</u> Day <u>4</u> Year <u>1958</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 6, 1906</u>		9. AGE (In years last birthday) <u>52</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>				10b. KIND OF BUSINESS OR INDUSTRY 				11. BIRTHPLACE (State or foreign country) <u>Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Jones</u>						14. MOTHER'S MAIDEN NAME <u>Aniella Tasker</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>Florence Johnson Sunderland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive C.V.R. disease</u> <u>1442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>2-10</u> , 19 <u>58</u> , to <u>4-4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-3</u> , 19 <u>58</u> , and that death occurred at <u>12:30</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Huntingtown, Md</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>[Signature]</u> M.D. PHYSICIAN'S NAME (Type) _____													
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF <u>6-8, 58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope</u>				22d. LOCATION (City, town, or county) (State) <u>Sunderland Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.E. Sewell, Prince, Fred, Md</u>						24a. REC'D BY REGISTRAR DATE <u>JUN 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6658 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06652

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>M. Beach</i> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wash DC</i> d. STREET ADDRESS <i>720 E. N.E.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>David Lewis Munos</i> First Middle Last		4. DATE OF DEATH Month <i>6</i> Day <i>9</i> Year <i>1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 9-1918</i>
9. AGE (In years last birthday) <i>39 yrs.</i>		10. IF UNDER 1 YEAR Months <i>11</i> Days <i>11</i> Hours <i>11</i> Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Agriculture Dept. U. S. Gov.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Taylor Spring Ill.</i>	
11. BIRTHPLACE (State or foreign country) <i>U. S. A</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Sebastian Munos.</i>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes. U.S. 11</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mary Munos</i>		Address <i>720 E. N.E. Washington, DC</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Swimming</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Had been swimming Came ashore and died</i>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) <i>Had been swimming Calvert M</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>5</i> a.m. <i>6/9</i> p.m. <i>58</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, etc.) <i>M. Beach Ches Bay Calvert M</i>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H.W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>6/12/58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St Agnes Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Hillsboro, Del.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Wm Lee's Sons</i>		24a. REC'D BY REGISTRAR <i>11 58</i>	
ADDRESS <i>300-4th St N.E. Wash D.C.</i>		24b. REGISTRAR'S SIGNATURE <i>W. J. ...</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6659 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06653

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bassett</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bassett</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Gray</u> First <u>William</u> Middle <u>Stacy</u> Last <u>Hall</u>				4. DATE OF DEATH Month <u>8</u> Day <u>26</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 24 1914</u>	
9. AGE (in years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working time even if retired) <u>Farmer</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Wm. Cochran</u>				14. MOTHER'S MAIDEN NAME <u>Marjorie Froese</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Louise Halling Bassett</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tuberculosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Died at 1030 AM</u> (a), stating the underlying cause last. (c) <u>Has been sick over a year</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVA. BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>. Inspection <input type="checkbox"/>. Inquiry <input type="checkbox"/>. and find that death resulted from: Natural causes <input checked="" type="checkbox"/>. Accident <input type="checkbox"/>. Suicide <input type="checkbox"/>. Homicide <input type="checkbox"/>. Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <u>H. W. Ward</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type)				DATE <u>6/26/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-28-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Pauls</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Frederick Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Hutchins</u>				ADDRESS <u>Dwight Md.</u>		24a. REC'D BY REGISTRAR <u>W. H. H. H.</u>	
24b. REGISTRAR'S SIGNATURE				DATE <u>JUL 1 '58</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06654

6660

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cabret</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Cabret</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Luxby</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cabret County Hospital</u>				d. STREET ADDRESS <u></u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ray Leroy STINNETT</u>				4. DATE OF DEATH <u>June 9, 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 27, 1916</u>	9. AGE (In years last birthday) <u>42</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Employee</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Charles County, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>George Stinnett</u>			
14. MOTHER'S MAIDEN NAME <u>Mother's Douchy</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>216-12-47N</u>				17. INFORMANT <u>Ruth Snister - Solomons, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>BRONCHIAL ASTHMA + EMPHYSEMA</u> DUE TO (c) <u>MYOCARDITIS (CHRONIC) + HYPERTENSION</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>MARCH 10, 1958</u> to <u>JUNE 9, 1958</u> , that I last saw the deceased alive on <u>June 8, 1958</u> , and that death occurred at <u>4 p. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Page C. Jett</u> M.D.				ADDRESS (Street, city or town, state) <u>Prince Frederick, Md</u>			
PHYSICIAN'S NAME (Type) <u>PAGE C. JETT M.D.</u>				DATE SIGNED <u>6/9/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 12, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Frederick, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Hackmeyer & Son - Mutual, Md</u>				24a. REC'D BY REGISTRAR <u></u>		24b. REGISTRAR'S SIGNATURE <u></u>	
DATE JUN 12 '58							

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>10/15/1885</u></p>		<p>4. Place of birth: <u>NEW YORK</u></p>	
<p>5. Date of death: <u>11/10/1955</u></p>		<p>6. Place of death: <u>NEW YORK</u></p>	
<p>7. Cause of death: <u>Myocardial Infarction</u></p>		<p>8. Duration of illness: <u>2 days</u></p>	
<p>9. Name of physician: <u>DR. J. H. BROWN</u></p>		<p>10. Name of attending nurse: <u>MRS. J. H. BROWN</u></p>	
<p>11. Name of informant: <u>JOHN J. SMITH</u></p>		<p>12. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>13. Name of informant: <u>JOHN J. SMITH</u></p>		<p>14. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>15. Name of informant: <u>JOHN J. SMITH</u></p>		<p>16. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>17. Name of informant: <u>JOHN J. SMITH</u></p>		<p>18. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>19. Name of informant: <u>JOHN J. SMITH</u></p>		<p>20. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>21. Name of informant: <u>JOHN J. SMITH</u></p>		<p>22. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>23. Name of informant: <u>JOHN J. SMITH</u></p>		<p>24. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>25. Name of informant: <u>JOHN J. SMITH</u></p>		<p>26. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>27. Name of informant: <u>JOHN J. SMITH</u></p>		<p>28. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>29. Name of informant: <u>JOHN J. SMITH</u></p>		<p>30. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>31. Name of informant: <u>JOHN J. SMITH</u></p>		<p>32. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>33. Name of informant: <u>JOHN J. SMITH</u></p>		<p>34. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>35. Name of informant: <u>JOHN J. SMITH</u></p>		<p>36. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>37. Name of informant: <u>JOHN J. SMITH</u></p>		<p>38. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>39. Name of informant: <u>JOHN J. SMITH</u></p>		<p>40. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>41. Name of informant: <u>JOHN J. SMITH</u></p>		<p>42. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>43. Name of informant: <u>JOHN J. SMITH</u></p>		<p>44. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>45. Name of informant: <u>JOHN J. SMITH</u></p>		<p>46. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>47. Name of informant: <u>JOHN J. SMITH</u></p>		<p>48. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>49. Name of informant: <u>JOHN J. SMITH</u></p>		<p>50. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>51. Name of informant: <u>JOHN J. SMITH</u></p>		<p>52. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>53. Name of informant: <u>JOHN J. SMITH</u></p>		<p>54. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>55. Name of informant: <u>JOHN J. SMITH</u></p>		<p>56. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>57. Name of informant: <u>JOHN J. SMITH</u></p>		<p>58. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>59. Name of informant: <u>JOHN J. SMITH</u></p>		<p>60. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>61. Name of informant: <u>JOHN J. SMITH</u></p>		<p>62. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>63. Name of informant: <u>JOHN J. SMITH</u></p>		<p>64. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>65. Name of informant: <u>JOHN J. SMITH</u></p>		<p>66. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>67. Name of informant: <u>JOHN J. SMITH</u></p>		<p>68. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>69. Name of informant: <u>JOHN J. SMITH</u></p>		<p>70. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>71. Name of informant: <u>JOHN J. SMITH</u></p>		<p>72. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>73. Name of informant: <u>JOHN J. SMITH</u></p>		<p>74. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>75. Name of informant: <u>JOHN J. SMITH</u></p>		<p>76. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>77. Name of informant: <u>JOHN J. SMITH</u></p>		<p>78. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>79. Name of informant: <u>JOHN J. SMITH</u></p>		<p>80. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>81. Name of informant: <u>JOHN J. SMITH</u></p>		<p>82. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>83. Name of informant: <u>JOHN J. SMITH</u></p>		<p>84. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>85. Name of informant: <u>JOHN J. SMITH</u></p>		<p>86. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>87. Name of informant: <u>JOHN J. SMITH</u></p>		<p>88. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>89. Name of informant: <u>JOHN J. SMITH</u></p>		<p>90. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>91. Name of informant: <u>JOHN J. SMITH</u></p>		<p>92. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>93. Name of informant: <u>JOHN J. SMITH</u></p>		<p>94. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>95. Name of informant: <u>JOHN J. SMITH</u></p>		<p>96. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>97. Name of informant: <u>JOHN J. SMITH</u></p>		<p>98. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>99. Name of informant: <u>JOHN J. SMITH</u></p>		<p>100. Name of informant: <u>JOHN J. SMITH</u></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6661 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06655**

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Avon Park</u> ✓ d. STREET ADDRESS <u>48X-3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frank</u> ^{first} <u>A</u> ^{Middle} <u>Truman</u> ^{Last} 4. DATE OF DEATH Month <u>6</u> Day <u>12</u> Year <u>1958</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept 23 1870</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>87</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (State or foreign country) <u>Germany</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Augustus J. Truman</u> 14. MOTHER'S MAIDEN NAME <u>Eliza Buffato</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>704-18-1536</u> 17. INFORMANT <u>John B. Ray Prince Frederick</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Vascular Renal Disease</u> <u>443X</u> DUE TO (b) <u>Cardiac Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in bedroom</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>	
ACTUAL SIGNATURE <u>H W Ward</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>H W Ward</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Ownip</u> DATE SIGNED <u>6/12/58</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> 22b. DATE THEREOF <u>June 14, 1958</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u> 22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Harkness & Son - Mutual, Md.</u> ADDRESS 24. REC'D BY REGISTRAR <u> </u> 25. REGISTRAR'S SIGNATURE <u> </u> DATE <u>June 16 '58</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH
THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of Death: *10/15/1918*

5. Place of Death: *Home*

6. Cause of Death: *Heart Disease*

7. Manner of Death: *Natural*

8. Signature of Medical Examiner: *[Signature]*

9. Date of Signature: *10/16/1918*

10. Signature of Coroner: *[Signature]*

11. Date of Signature: *10/16/1918*

12. Signature of Registrar: *[Signature]*

13. Date of Signature: *10/16/1918*